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DIVISION OF FORENSIC SCIENCE
DEPARTMENT OF JUSTICE
275 West Front Street, Missoula, MT 59802 (406) 728-4970

Ronald L. Rivers, M.D.
State Medical Examiner

Arnold B. Melnikoff
Laboratory Bureau Chief

Dawn M. Kangas
Administrative Assistant

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NEW DEATH INVESTIGATION COURSE

April 30 - May 3 - Tucson, Arizona

Interpretation of Patterns in Injury and Death
(Designed for pathologists, attorneys, coroners, and law enforcement)
Cost - $450 - $550

NEW REPORTS

By now all of the coroners should have received the new coroners report form, and the law enforcement agencies the new physical evidence examination forms. Please call us if you need more forms or have any questions.

NEW DRUG

Larry Pederson, Chief Chemist, has received 1/4 and 1/2 gram packets of methamphetamine in powdered form. Since look-alike stimulant tablets and capsules gained popularity, real "speed" or "crank" (amphetamine and methamphetamine) has been rarely seen.

FEBRUARY 1984
DEATH INVESTIGATION PROBLEMS
R. L. Rivers, M.D. and
William J. Brady, M.D.

The following are true Oregon medical examiner cases that demonstrate problems that can be prevented. Slight modifications have been made in the stories to reflect a coroners system.

1) A deputy coroner was called to a young man's home late one evening. The coroner was told that his 60 year-old father had a long history of heart disease and collapsed suddenly in his bedroom. Although the coroner had never seen his father before, he was encouraged both by the emotional son and the anxious funeral directors to promptly certify the death and allow the body to be removed. He complied.

   After the body was cremated, the coroner learned that the victim was not "the individual's father" and had been certified and cremated under a fictitious name. The "son" has moved and cannot be located.

2) A deputy coroner was called to investigate the death of an elderly traveler who collapsed and died suddenly in a local motel. The family gave the coroner a detailed history of heart disease, which the coroner carefully checked. The follow-up documenting medical history required multiple phone calls, and no death certificate was signed for over two weeks. Enraged at this delay and inconvenience, the family complained to the Governor's office.

3) The coroner's office was notified of the death of a 70 year-old man who was ill with terminal cancer and died in his home. The coroner visited the scene and noted that the body in the bedroom seemed inappropriately positioned and was unusually pink. He made discreet inquiries and shortly discovered that the body had been removed from the garage where an automobile was found with a vacuum cleaner hose still taped to the tailpipe.

QUESTION:

What problems do these cases illustrate?

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ANSWERS:

1) One of the easiest mistakes in death investigation is a failure to be critically skeptical and consciously careful about "presumed identification." The coroner must in every case adopt a cautious and careful attitude toward identification and documentation of the circumstances of the fatal collapse and past history of the individual.

2) There is an inevitable and human tendency to postpone and delay "routine" tasks causing significant problems both for the family and ultimately for the state office.

3) The coroner visited the scene rather than simply "viewing" the body in a mortuary. At the scene, the coroner was not perfunctory but rather observant and careful. Calls at inconvenient hours or under hectic circumstances are fraught with peril. The conscientious coroner proved to be thorough and attentive and handled a family tragedy with honesty and compassion.